

Washington Medicaid Integration Partnership
Summary of Issues
February 17, 2004
Everett PUD
2:30 – 5:30

REGIONAL SUPPORT NETWORK (RSN) ISSUES AND CONCERNS:

1. Crisis System

How will population receive crisis services?

DSHS: System will not change; crisis services will remain with the RSN.

How will crisis services be coordinated between RSN and WMIP contractor?

DSHS: The Care Coordinator in the WMIP plans will be the contact person if a WMIP client enters the hospital, needs outpatient services, etc. These details of implementation can be worked out once a health plan or health plans are awarded contracts.

2. Existing population may receive less services if funding is diverted to WMIP

Housing needs, social rehabilitation, “regeneration of hope.”

Disproportionate cut in funding.

Services to non-Medicaid clients

Services to other counties impacted

Fewer dollars and less resources

Impact on other counties

Severely mentally ill will suffer the most

Amount of resources cannot keep pace with amount of clients

DSHS: DSHS acknowledges that the mental health system (Medicaid and non-Medicaid) is an underfunded system. We are working on CMS approval of RSN rates statewide at the same time we are working to create fair rates for the WMIP project. The issue of non-Medicaid clients receiving services is a CMS issue, which will change funding for RSNs whether or not WMIP is implemented.

The transfer of funds from the RSN is proportionate to services being transferred to the WMIP plans’ responsibility. In fact, a portion of outpatient administration funds will remain with the RSN. The impact to NorthSound in terms of dollars is less than the projected increase of funds in the upcoming biennium.

3. Carve Out/Leaving inpatient care with RSN and outpatient care with WMIP

Impact on evaluation design

Impact on evaluation results

Impact on care coordination

Impact on clients

Cost shifting potential

Risk left with RSN

DSHS: This compromise was developed because of RSN concerns that transferring the entire capitation would create an untenable situation for the entire NorthSound region. DSHS acknowledges that careful monitoring and evaluation will need to occur in order to guard against cost-shifting from outpatient to inpatient service utilization. We have requested volunteers to serve on a local evaluation team, because local experts will be the best resource in the design and implementation of the quality improvement and evaluation effort.

4. Using an existing pool of money without additional resources

Disintegration of RSN

Less services to those in need

Impact on other counties

Amount of resources cannot keep pace with amount of clients

WMIP integrates funding, not services

DSHS: Resources for state and federally funded services will be limited in the future regardless of WMIP implementation. However, DSHS does not want to see regional systems of care damaged in the process. It is our hope that WMIP will achieve cost-savings that can be used to improve care and lead to clinical integration, with the first step in that process being financial integration.

5. No official communication

Community meetings are too late

Request for Proposals already issued

DSHS not willing to change the overall scope of the project

No written communication, only verbal

DSHS has made the following attempts to keep interested people in the loop about WMIP:

- Our first public meeting on WMIP was held in January 2003.
- Teleconferences with several RSNs, including Northsound, began in January 2003, including MHD and MAA staff.
- A formal letter followed to the RSNs in February 2003, from Tim Brown, Assistant Secretary for Health and Rehabilitative Services Administration, requesting their participation in planning and development of the WMIP project.
- Meetings with Community Mental Health Council and other stakeholders during 2003.
- Meetings with Snohomish County Human Services during the summer and fall of 2003.
- Public meetings in Snohomish County in January and February 2004.
- Updates on WMIP website.

The scope of the project has changed in response to stakeholder feedback, including the delay of long term care services as part of the integrated set of benefits, the separation of outpatient and inpatient mental health benefits, and the

carve-out of opiate substitution treatment from the WMIP benefits. Additional time has been added to the implementation schedule, so that even more planning can be done at the local level.

STILLAGUAMISH AND TULALIP ISSUES AND CONCERNS

1. Violation of the Centennial Accord
No government-to-government discussion

DSHS: DSHS acknowledges the mistake in not initiating consultation right away when Snohomish County was identified as the pilot site for WMIP. We will redouble our efforts to hold meaningful government-to-government discussions with tribes in the pilot area. We are also willing to meet with tribes outside the pilot area if they are interested in having discussions about the project.

2. Impact to services to tribal and non-tribal members
No tribal representation
No consumer representation
Lack of notification

DSHS: We will absolutely allow freedom of choice for enrolled tribal members, and will not use the “auto-enrollment” method for any clients identified to DSHS as tribal members. We will involve tribal representatives in the decisions about how to communicate with tribal members or non-tribal clients who have disability-related Medicaid benefits about the option of WMIP enrollment. We have removed the opiate substitution benefit from WMIP as a result of concerns expressed by the Stillaguamish tribe.

3. Federal encounter rates for tribes

DSHS: DSHS is reviewing how to proceed with concerns about the federal encounter rate for its services, especially as it relates to services provided to non-tribal members. This is not unique to WMIP.

COMMUNITY AND STAKEHOLDER ISSUES AND CONCERNS

1. Lack of Community and Stakeholder Input
Needs of rural areas not addressed
Needs of impacted counties not addressed
Needs of people with psychiatric disabilities not addressed

DSHS: We have held two public meetings since Snohomish County was identified as the pilot site, and will continue to hold public meetings as implementation proceeds. We have extended the timeline by three months in order to expand communication with local stakeholders. We have proposed three

work groups to provide input on evaluation and monitoring, client education, and client enrollment. Others may be formed, such as an overall advisory committee, which may be the best way to communicate about the issues raised above.

The rural areas in Snohomish County are currently underserved in the present system. WMIP has a greater ability to serve those needs, as provider networks will be monitored on a yearly basis through managed care. In the Fee-for-Service system, there is no monitoring of provider networks.

Clients and client advocates are encouraged to join in the process of discussion regarding WMIP so that the needs of all clients are addressed in a thorough and well thought out manner.

2. Possible discrimination against clients who have been in jail or state hospitals
No consumer advocates
Cultural needs not met
Who is eligible for services and who isn't eligible for services?

DSHS: There was a miscommunication or misunderstanding at the previous meeting; WMIP will not discriminate against clients who have been in jail or state hospitals. There will be multiple avenues for advocacy, including the WMIP plans' care coordinators and the RSN ombudsman role. DSHS staff will review mechanisms to address clients' cultural needs as part of the evaluation of health plans' readiness to enroll clients in WMIP. Clients' eligibility for WMIP enrollment is determined by their DSHS program eligibility, i.e. SSI and SSI-related benefits.

3. What is the impact on the larger system?

DSHS: We recognize the request to address this issue as part of the design and evaluation of WMIP. This could be part of the role of a local advisory committee.

4. How will we integrate Alcohol and Substance Abuse treatment?

DSHS: We are asking health plans to address screening, outreach, and provision of alcohol and substance abuse treatment in their response to the RFP. The providers will be certified by the state, as they are currently, and will use TARGET to report service utilization.

5. What is the impact on independent providers (long-term care workers)?

DSHS: When long term care is incorporated in the benefit package, WMIP health plans will contract with the independent providers who serve their clients. DSHS will provide plans information on these providers, and the plans will also ask clients who they want to use as their care provider.

6. Where will the savings go?

Benefits must be demonstrated for both clients and providers
Financial benefits should be returned to clients and providers and not back to the bureaucracy

DSHS: DSHS does not think there will be short-term savings related to WMIP. Providers may see direct benefits from participation with health plans, or indirect benefits such as clients showing up for appointments and having better compliance. In the long term, savings will result from improved care, and will be used to prevent future cuts to eligibility and services.

7. When do consumers get a voice in their care?

DSHS: The Care Coordinator in the WMIP plans will ensure that consumers participate in the development of their care plan.

8. Will clients be sent to the hospital more often to shift costs from WMIP?

DSHS: It is not in the health plans' interest to disrupt care that already works well. We will monitor continuity of care and utilization of services closely.

9. Potential for more than one contractor

Qualifications of contractors

Do potential contractors have community-based services in other projects?

DSHS: There is the potential that more than one health plan will be qualified to contract for WMIP. The evaluation tool is available on our website; in addition, the Office of the Insurance Commissioner reviews health plans for financial stability and other state requirements. At least one potential bidder has implemented an integrated health plan project which includes community-based services.

10. Evaluation

Negative impact upon consumers if evaluation takes place during implementation
Skewed analysis between those who have more severe needs and those who have less severe needs (mental health)

DSHS: DSHS has invited participation in the design and implementation of the quality monitoring and evaluation process for WMIP. The analysis of process and outcome measures should be able to take into account the different severity level and needs of clients.

11. Timing

Not enough time for proper integration

Not enough time for input

Not enough time to develop system

DSHS: We have extended the implementation by several months in order to address these concerns. Long term care will be incorporated later in the project, so that plans and providers are ready for implementation.

RATES ISSUES AND CONCERNS

1. Incentive to serve clients with high medical and low mental health costs
Adverse selection

DSHS: As stated before, we will monitor the implementation closely to ensure that care is not disrupted. We are willing to do retrospective risk-adjustment of mental health rates if adverse selection occurs.

2. Actuarial soundness in question
Statewide rates are not an accurate reflection of Snohomish County rates

DSHS: The 12 rate cells reflect relative differences in experience. Statewide experience is used to normalize the relative costs. Once the total dollars are projected forward, the rates balance out in the aggregate, even though any given rate cell will not match Snohomish County experience.

3. Increased administrative costs
Increased provider costs
More complex system
Duplicative system

DSHS: Providers should work with the health plans to help decrease their administrative costs. Duplication of some administrative services should be reduced. Authorization of services should be simplified by the role of care coordinator.